Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13202

4 - ER URGENT

000001

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: [redacted] AC#: [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex 2 pg 32 of 49

REGISTRATION DATE: 11/08/98 MD: [redacted] MD

FAMILY DOCTOR: DOCTOR NOT COLLECTED PA:

DISCHARGE DIAGNOSES
1. Acute abdominal pain, mostly resolved, etiology undetermined.
2. History of left ovarian cyst.

HISTORY OF PRESENT ILLNESS: This is a 22-year-old female with a history of ovarian cyst, who is on birth control pills as well, who came in at 3:40 in the morning with about 45 minutes of severe pain, pointing to her right lower abdomen and her right upper abdomen. No radiation. She has been feeling nauseous since then. The patient apparently felt better around the time I came into the room.

PHYSICAL EXAMINATION: Overweight 22-year-old female. Afebrile. Vital signs are within normal limits. Slightly elevated heart rate of 104. Left lower quadrant is nontender. Right lower quadrant is tender as well as the right and left upper quadrants and mid abdomen with multiple pockets of gas on palpation.

DIAGNOSTIC TESTS: CBC and pregnancy test were ordered with the patient having a negative pregnancy test and white count of 14,000.

EMERGENCY DEPARTMENT COURSE: The patient was feeling much better after being treated with IV fluids, one liter of normal saline over an hour. Although she did have an elevated white count and as her pain was nearly completely resolved with no treatment and such a short duration, she was treated as if this was a possible early gastroenteritis versus food poisoning, unlikely that this is any kind of a surgical presentation due to the very brief and resolved nature of this. She was treated with 60 of Toradol IM and given one dose of Compazine suppository for discharge. She is to return if her condition worsens. She was advised clear fluids only for the next several hours, gradually increase her diet, to start with sugars.

[redacted] DD: 11/08/98 DT: 0623 TD: 11/08/98 TT: 1021 JOB NO: [redacted]

000002

[redacted]

Name [redacted] D.O.B./Age: [redacted]

Walk In ____ Amb ____ Ill. ____ Inj. ____ **Tri. Levl.** [redacted]

CC #1 abd pain #2 ____

Triage Reason MD

X-Ray

☐ Waiting Rm ☑ Emergent ☐ Urgent ☐ OBS SEC NOT. CI

P.C.P. Current Meds: BCP

Med Hx:

hx ⓒ Ovarian Cyst

Pain Scale: 1 2 3 4 5 6 7 8 9 10	Time	BP	P	R	T	WT	Pulse 0 2%	Glucoscan	Last Tet.	LMP
	03:35	100/54	104	20	97.5					1 wk ago
	05:15	100/60	100	Time 16:40	BP	P	V / OD	V / OS	UA Dip	neg (not sent)

Allergies: NKMA

Time	Progress Notes
0320	Hx pain across lower abd that started suddenly about 03:00 & is severe - "10" of "10". Skin a little pale, diaphoretic. Hx nausea. abd tender to palpation in (R) UQ to (R) CVA across lower abd (worse on R). Hx feeling weak. had french fries for lastmeal. unable to urinate @present. [redacted]
5:15	Pain gradually subsided. color now pink. Nausea stopped about 45 min ago/arrival. Still some pain when moving around but much more comfortable.
30	Home c friend. [redacted]

IV Gauge/Site #1 18 (L) FA #2 ____

Orders	Dose	Route	Rate	Site	Time	Infused	RN
① NS 1L							
② Tylenol	30mg	PO			60		
③ Compazine	25mg						

[redacted]

C 3

ROOM # [redacted]

[redacted]

Consultant: Time: On Site:

C Spi [redacted] Comments: [redacted]

MD [redacted] ID# [redacted] RN [redacted]

MD ID# RN

PA ID# RN

Tetanus Co. Info Sheet ☐ Site Time

Lot # Exp. Date RN

Disch. Admit Valuable Envelope #

DX MD Report To

Additional Documents: CONT ASTH TRAUMA TRANS AMA U.C AMI C.S. S & R PERMIT GUIDE

☐ Dictated

[redacted]

MEDICAL RECORDS

000003

[redacted]

Patient: [redacted]
Age: 22 YRS SEX:F
Med Rec Number: [redacted]
Financial Number: [redacted]
Admit Date: 08NOV98

Location: [redacted]
Physician(s): [redacted]

OUTPATIENT REPORT

ENDOCRINOLOGY

Procedure: S.PREG
08NOV98 0415 NEGATIVE

HEMATOLOGY

----- COMPLETE BLOOD COUNT -----

Procedure:	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW
Reference:	5.0 - 10.0	4.00 - 5.20	12.0 - 16.0	36.0 - 46.0	80 - 99	25.0 - 35.0	31.0 - 36.0	11.5 - 14.5
Units:	K/CUMM	M/CUMM	G/DL	%	FL	PG	G/DL	%
08NOV98 0415	14.1 H	4.65	13.9	40.5	87	29.9	34.3	12.9

----- AUTOMATED DIFFERENTIAL -----

Procedure:	NEUTRO	LYMPH	MONO	EOS	BASO
Reference:	40 - 75	16 - 46	0 - 9	0 - 4	0 - 2
Units:	%	%	%	%	%
08NOV98 0415	70	24	4	1	1

Procedure:	NEUTRO ABS	LYMPH ABS	MONO ABS	EOS ABS	BASO ABS
Reference:	1.8 - 7.8	1.0 - 3.4	.0 - .8	.0 - .4	.0 - .2
Units:	K/CUMM	K/CUMM	K/CUMM	K/CUMM	K/CUMM
08NOV98 0415	9.9 H	3.4	.6	.1	.1

Procedure:	PLATELET CT
Reference:	150 - 350
Units:	K/CUMM
08NOV98 0415	167

Report Received by [redacted] on
11/11/98 e-mail / e-fax
Route
Reviewed by [redacted] 11/11/98
Action

Legend:
H = High

END OF REPORT

PRINTED: 11NOV98 1502 [redacted]

MedWatch #13202
2&4,5/99 JAH
Ex#1 pg 3 of 16

[redacted]

Patient: [redacted]
Age: 22 YRS SEX:F
Med Rec Number: [redacted]
Financial Number: [redacted]
Admit Date: 08NOV98

Location: [redacted]
Physician(s): [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

ENDOCRINOLOGY

Procedure: S.PREG
08NOV98 0415 NEGATIVE

HEMATOLOGY

COMPLETE BLOOD COUNT

Procedure:	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW
Reference:	5.0 - 10.0	4.00 - 5.20	12.0 - 16.0	36.0 - 46.0	80 - 99	25.0 - 35.0	31.0 - 36.0	11.5 - 14.5
Units:	K/CUMM	M/CUMM	G/DL	%	FL	PG	G/DL	%
08NOV98 0415	**14.1** H	4.65	13.9	40.5	87	29.9	34.3	12.9

AUTOMATED DIFFERENTIAL

Procedure:	NEUTRO	LYMPH	MONO	EOS	BASO
Reference:	40 - 75	16 - 46	0 - 9	0 - 4	0 - 2
Units:	%	%	%	%	%
08NOV98 0415	70	24	4	1	1

Procedure:	NEUTRO ABS	LYMPH ABS	MONO ABS	EOS ABS	BASO ABS
Reference:	1.8 - 7.8	1.0 - 3.4	.0 - .8	.0 - .4	.0 - .2
Units:	K/CUMM	K/CUMM	K/CUMM	K/CUMM	K/CUMM
08NOV98 0415	**9.9** H	3.4	.6	.1	.1

Procedure:	PLATELET CT
Reference:	150 - 350
Units:	K/CUMM
08NOV98 0415	167

MedWatch #13202
2/4,5/99 JAH
Ex 2 pg 33 of 49

Symbols and Notes:
H = High

END OF REPORT

PRINTED: 09NOV98 0422 [redacted]

OUTPATIENT

OTHER ER VISITS

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: [redacted] AC#: [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex 2 Pg 36 of 49

REGISTRATION DATE: 08/22/98 MD: [redacted]

FAMILY DOCTOR: DOCTOR NOT COLLECTED PA:

DIAGNOSIS: Abdominal pain probable ovarian cyst, complained of abdominal pain.

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old female, gravida 2, para 1-0-1-1. Last menstrual period was August 6, 1998, presents with left lower quadrant pain, intermittent for the last 12 hours. The patient states that she has not taken any over-the-counter pain medications. The patient states that she has a history of some episodes of left lower quadrant pain, diagnosed in past and the emergency department as an ovarian cyst. The patient had an ultrasound done within the last six months, which she tells me was negative, however it was not during the time when she was having any pain. The patient states that the pain that she has today is her usual discomfort and pain. The patient denies any vaginal bleeding, dyspareunia, or urinary symptoms. The patient denies any previous sexually transmitted diseases.

MEDICATIONS: Birth control pills.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: The patient does not smoke and does not drink.

PHYSICAL EXAMINATION: Pulse initially 136 and on my examination 80 and regular. Blood pressure 120/70, afebrile. HEENT: Normocephalic, atraumatic, and anicteric. Neck is supple. Lungs are clear to auscultation. Heart: Regular rate and rhythm. Abdomen is soft. Tender left lower quadrant. No rebound, guarding. No organomegaly. No masses. No CVA tenderness. Pelvic examination: There is very mild cervical motion tenderness. The os is closed. There is white vaginal discharge. There appears to be somewhat of a fullness in the left adnexa with some tenderness to this area.

DIAGNOSTIC TESTS: Pregnancy test is negative. White count is elevated at 13,700, no left shift. Urinalysis was dip stick negative.

EMERGENCY DEPARTMENT COURSE: I asked OB/GYN resident to evaluate the patient as she has been followed in the [redacted] previously. After they by evaluation, they feel comfortable, this is most likely to be an ovarian cysts process, and recommended outpatient ultrasound. Recommend close follow up with around health center.

PATIENT NAME: [redacted]
MRN: [redacted]

DISPOSITION: On discharge, the nurse noted the heart rate to be 138. On my exam, heart rate is 88 and regular. Hemoglobin and hematocrit were normal.

Disposition is as above. The patient was to follow up with [redacted] outpatient ultrasound. The patient was to return to the emergency department and/or call [redacted] for increasing pain.

[redacted] DD: 08/22/98 DT: 0703 TD: 08/22/98 TT: 2140 JOB NO: [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex2 p37 of 49

000008

[redacted]

Patient: [redacted]
Age: 21 YRS SEX:F
Med Rec Number: [redacted]
Financial Number [redacted]
Admit Date: 22AUG98

Location: [redacted]
Physician(s): [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

HEMATOLOGY

Procedure:	PLATELET CT	
Reference:	150 - 350	
Units:	K/CUMM	
22AUG98 0400	171	

MedWatch #13202
2/4,5/99 JAH
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MICROBIOLOGY - UCV

UCV CHLAM DNA MB-98-30040

COLLECTED:	22AUG98	0425
RECEIVED:	22AUG98	0427
STARTED:	22AUG98	0429

SOURCE: VAGINAL
VAGINAL
**********FINAL REPORT**********
FINAL 22AUG98 1134
NEGATIVE FOR CHLAMYDIA VIA DNA PROBE

UCV GC DNA PROBE [redacted]

ED:	22AUG98	0425
ED:	22AUG98	0427
ED:	22AUG98	0429

SOURCE: VAGINAL
VAGINAL
**********FINAL REPORT**********
FINAL
NEGATIVE FOR NEISSERIA GONORRHOEAE VIA D

UCV TRICH PREP [redacted]

ED:	22AUG98	0425
ED:	22AUG98	0427
ED:	22AUG98	0428

SOURCE: VAGINAL
TRICH
**********FINAL REPORT**********
FINAL
NO MOTILE TRICHOMONAS OBSERVED

END OF REPORT

PRINTED: 24AUG98 0418 [redacted]

[redacted]

Patient: [redacted]
Age: 21 YRS SEX:F
Med Rec Number: [redacted]
Financial Number: [redacted]
Admit Date: 22AUG98

Location [redacted]
Physician(s): [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex2 pg 40 of 49

EMERGENCY DEPARTMENT LABORATORY REPORT

ENDOCRINOLOGY

Procedure: S.PREG
22AUG98 0400 NEGATIVE

HEMATOLOGY

COMPLETE BLOOD COUNT

Procedure:	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW
Reference:	5.0 - 10.0	4.00 - 5.20	12.0 - 16.0	36.0 - 46.0	80 - 99	25.0 - 35.0	31.0 - 36.0	11.5 - 14.5
Units:	K/CUMM	M/CUMM	G/DL	%	FL	PG	G/DL	%
22AUG98 0400	**13.6** H	4.79	14.2	42.1	88	29.7	33.8	13.5

AUTOMATED DIFFERENTIAL

Procedure:	NEUTRO	LYMPH	MONO	[redacted]
Reference:	40 - 75	16 - 46	0 - 9	
Units:	%	%	%	
22AUG98 0400	71	26	3	

Procedure:	NEUTRO ABS	LYMPH ABS	MONO
Reference:	1.8 - 7.8	1.0 - 3.4	.0 -
Units:	K/CUMM	K/CUMM	K/CU
22AUG98 0400	**9.6** H	**3.5** H	.4

MANU

Procedure:	SEGS	BANDS	LYMPHS
Reference:	40 - 75	0 - 10	16 - 46
Units:	%	%	%
22AUG98 0400	74	3	21

MORPHOLOGY

Procedure:	PLT EST	ANISO
22AUG98 0400	NORMAL	NORMAL f

NISO..... RBC MORPHOLOGY APPEARS NORMAL
FOOTNOTE ADDED ON 22AUG98 AT 0435 BY [redacted]

ymbols and Notes:
- High, f - Footnote

Continued Next Page ...

PRINTED: 24AUG98 0418

000010

OUTPATIENT

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: [redacted] AC#: [redacted]

REGISTRATION DATE: 04/07/98 MD: [redacted] MD

FAMILY DOCTOR: DOCTOR NOT COLLECTED PA:

DIAGNOSIS: Abdominal pain.

HISTORY OF PRESENT ILLNESS: The patient is a 21-year-old who complains of left lower quadrant abdominal pain typical to the pain that she has been having for the past eight months. The patient denies any nausea with no vomiting, no change in bowels, no dysuria, and no vaginal discharge. Last menstrual period was one month ago, within normal limits.

PAST MEDICAL HISTORY: Significant for a questionable ovarian cyst.

PHYSICAL EXAMINATION: The patient is a well-developed female in no distress, alert and, oriented. White sclerae. Pink conjunctivae. Oropharynx: Moist. No JVD. Lungs are clear. Heart is regular without murmurs. Abdomen: Positive left lower quadrant tenderness, no rebound, no guarding, no masses, and good bowel sounds. Extremities: Negative deformity.

DIAGNOSTIC TESTS: Urinalysis and urine pregnancy are negative.

EMERGENCY DEPARTMENT COURSE: The patient was given Motrin 800 mg which did resolve the patient's pain.

DISPOSITION: The patient was discharged to home and told to take medicines as directed and return for any worsening or persistent symptoms.

CONDITION ON DISCHARGE: Good.

[redacted] DD: 04/08/98 DT: 0355 TD: 04/08/98 TT: 0716 JOB NO: [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex2 pg 41 of 49

000011

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: [redacted] AC#: [redacted]

REGISTRATION DATE: 11/30/97 MD: [redacted] MD

FAMILY DOCTOR: PA:

DIAGNOSIS: Rule out possible ovarian cyst.

HISTORY OF PRESENT ILLNESS: The patient is a 21-year-old female who had been seen in the emergency room on two other occasions with possible ovarian cyst type pain, who has noted this evening, after having intercourse, of a vague suprapubic abdominal pain, left greater than right and now presents for evaluation.

PAST MEDICAL HISTORY: She has not had appropriate follow up for ultrasound and has not kept her previous outpatient GN appointments.

PHYSICAL EXAMINATION: Overweight female in minimal discomfort. Vital signs stable. Temperature afebrile. Abdomen is soft, good active bowel sounds. No appreciable masses or hepatosplenomegaly. Pelvic exam: Normal external genitalia. Vaginal vault was within normal limits. Bimanual exam: There is some cervical motion tenderness appreciated and some questionable left adnexal tenderness appreciated.

DIAGNOSTIC TESTS: OB screen was sent. HCG was negative.

EMERGENCY DEPARTMENT COURSE: Case was discussed with GYN who came to evaluate the patient and agreed that she does have some discomfort. Denied that she had any cervical motion tenderness, but felt that she should be followed up and have an outpatient sonogram. There appeared to be no need for any further emergency diagnostic workup at this time.

DISPOSITION: The patient will be discharged on Percocet 1 to 2 tablets q 4h p.r.n.

CONDITION ON DISCHARGE: Stable.

[redacted] DD: 11/30/97 DT: 0845 TD: 11/30/97 TT: 0955 JOB NO: [redacted]

MedWatch #13202
2/4,5/99 JAH
Ex 2 p943 of 49

000012

[redacted]

Patient: [redacted]
Age: 21 YRS SEX:F
Med Rec Number: [redacted]
Financial Number [redacted]
Admit Date: 30NOV97

Location [redacted]
Physician(s) [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

ENDOCRINOLOGY

Procedure:	S.PREG
30NOV97 0415	NEGATIVE

HEMATOLOGY

COMPLETE BLOOD COUNT

Procedure:	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW
Reference:	5.0 - 10.0	4.00 - 5.20	12.0 - 16.0	36.0 - 46.0	080 - 099	25.0 - 35.0	31.0 - 36.0	11.5 - 14.5
Units:	K/CUMM	M/CUMM	G/DL	%	FL	PG	G/DL	%
30NOV97 0415	**12.0** H	4.77	14.2	41.6	087	29.8	34.2	13.4

AUTOMATED DIFFERENTIAL

Procedure:	NEUTRO	LYMPH	MONO	EOS	BASO
Reference:	40 - 75	16 - 46	0 - 9	0 - 4	0 - 2
Units:	%	%	%	%	%
30NOV97 0415	75	21	3	1	0

Procedure:	NEUTRO ABS	LYMPH ABS	MONO ABS	EOS ABS	BASO ABS
Reference:	1.8 - 7.8	1.0 - 3.4	.0 - .8	.0 - .4	.0 - .2
Units:	K/CUMM	K/CUMM	K/CUMM	K/CUMM	K/CUMM
30NOV97 0415	**9.0** H	2.5	.4	.1	.0

MANUAL DIFFERENTIAL

Procedure:	SEGS	BANDS	LYMPHS	MONOS	EOS
Reference:	40 - 75	0 - 10	16 - 46	0 - 9	0 - 4
Units:	%	%	%	%	%
30NOV97 0415	66	3	22	7	2

MORPHOLOGY

Procedure:	PLT EST	ANISO
30NOV97 0415	CLMP-NOR	NORMAL f

ANISO..... RBC MORPHOLOGY APPEARS NORMAL

MedWatch #13202
2/4,5/99 JAH
Ex 2 pg 44 of 49

Symbols and Notes:
H = High, f = Footnote

Continued Next Page ...

PRINTED: 02DEC97 0502

000013

OUTPATIENT

[redacted]

Patient: [redacted]
Age: 21 YRS SEX:F
Med Rec Number: [redacted]
Financial Number: [redacted]
Admit Date: 30NOV97

Location [redacted]
Physician(s): [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

HEMATOLOGY

Procedure:	PLATELET CT	
Reference:	150 - 350	
Units:	K/CUMM	
30NOV97 0415	141 L	

MICROBIOLOGY - UCV

UCV CHLAM DNA [redacted]
SOURCE: VAGINAL
VAGINAL

COLLECTED: 30NOV97 0630
RECEIVED: 30NOV97 0638
STARTED: 30NOV97 0638

**********FINAL REPORT**********

FINAL — 01DEC97 1342

NEGATIVE FOR CHLAMYDIA VIA DNA PROBE

UCV GC DNA PROBE [redacted]
SOURCE: VAGINAL
VAGINAL

COLLECTED: 30NOV97 0630
RECEIVED: 30NOV97 0638
STARTED: 30NOV97 0638

**********FINAL REPORT**********

FINAL 01DEC97 1344

NEGATIVE FOR NEISSERIA GONORRHOEAE VIA DNA PROBE

PENDING RESULTS

30NOV97 0522 C UCV PROCES

MedWatch #13202
2/4,5/99 JAH
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Symbols and Notes:
L = Low

END OF REPORT

PRINTED: 02DEC97 0502 [redacted]

000014

OUTPATIENT

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: AC#:

REGISTRATION DATE: 09/30/97 MD: [redacted] MD

FAMILY DOCTOR: PA:

DIAGNOSIS: Abdominal pain, etiology probably ovarian cyst related.

HISTORY OF PRESENT ILLNESS: The patient is a 21-year-old white female with a previous history of frequent problems with ovarian cyst with pain, etc. She presents with complaint of lower abdominal pain since. Apparently, the pain was very sharp and acute initially, but now it is a kind of dull and throbbing, although it seems to be improved. No back pain or chills. No fever, dysuria, hematuria, or urinary frequency. She is on birth control pills. She denies vaginal discharge, chills, or fever. Last menstrual period was on September 20, and it was a normal period. She gave a normal vaginal birth last January.

PHYSICAL EXAMINATION: The patient is a healthy-looking female in no extremis. Vital signs are stable. Abdomen is soft and benign. Extremities: Unremarkable. No CVA tenderness.

EMERGENCY DEPARTMENT COURSE: I reassured her, I dispensed Percocet for pain control as she was still uncomfortable.

DISPOSITION: She was discharged home thereafter in stable condition with instructions. She plans to see her gynecologist tomorrow. If her symptoms continue or if she took a turn for the worse, she is to return to the emergency department.

CONDITION ON DISCHARGE: Stable.

[redacted] DD: 09/30/97 DT: 0436 TD: 09/30/97 TT: 1017 JOB NO: [redacted]

MedWatch #13202
2/4,5/99 JAH

Ex 29 46 of 49

[redacted]

EMERGENCY DEPARTMENT REPORT

PATIENT NAME: [redacted] MRN: [redacted]

BIRTH DATE: [redacted] AC#: [redacted]

REGISTRATION DATE: 08/13/97 MD: [redacted] MD

FAMILY DOCTOR: PA:

DIAGNOSIS: Rupture, ovarian cyst.

HISTORY OF PRESENT ILLNESS: The patient is a 20-year-old female while having sex developed sudden onset of lower abdominal pain which was bilateral in nature. She is two weeks into her menstrual cycle. She is four or five months post partum. She is otherwise healthy. She has a history of ovarian cyst.

PHYSICAL EXAMINATION: Vital signs are stable. Temperature is 99.2 degrees. She has had no fever or discharge. Neck examination is normal. Chest is clear. Cardiac is regular. Abdomen is without suprapubic tenderness. No rebound or guarding. Pelvic examination: Mild tenderness in the pelvic region. No masses noted. Uterus is normal. No cervical motion tenderness and no discharge.

DIAGNOSTIC TESTS: Urinalysis was negative. White count was 9.8 with an H&H of 13. 6 and 40.2. Pregnancy test was negative.

EMERGENCY DEPARTMENT COURSE: Demerol 50 mg, Vistaril 25 IM with relief of pain.

DISPOSITION: The patient was discharged with 6 Percocet tablets 1-2 every four hours for pain. The patient is to followup tomorrow with doctor if not better. Bed rest for 24 hours.

[redacted] DD: 08/14/97 DT: 0129 TD: 0 TT: JOB NO: [redacted]

MedWatch #13202
2/4,5/99 JAH
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000016

[redacted]

Patient: [redacted]
Age: 20 YRS SEX:F
Med Rec Number: [redacted]
Financial Number [redacted]
Admit Date: 13AUG97

Location [redacted]
Physician(s): [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

ROUTINE URINE

Procedure:	COLOR	TURBIDITY	PH	SPEC GRAV	PROTEIN	GLUCOSE	KETONES	BILIRUBIN
Reference:			4.8 - 8.0	1.001 - 1.035	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
14AUG97 0035	YELLOW	ABSENT	7.0	1.015	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE

Procedure:	BLOOD	UROBILINOGEN	NITRITE	ESTERASE
Reference:	NEGATIVE	NORMAL	NEGATIVE	NEGATIVE
14AUG97 0035	NEGATIVE	NORMAL	NEGATIVE	NEGATIVE

MICROSCOPIC

Procedure:	U WBC	U RBC	SQUAMOUS EPI
Reference:	/HPF	/HPF	/HPF
14AUG97 0035	0-1	NEGATIVE	MODERATE

MICROBIOLOGY - URINE

URINE CULTURE [redacted]
SOURCE: URINE
VOIDED

COLLECTED: 14AUG97 0035
RECEIVED: 14AUG97 0041
STARTED: 14AUG97 0041

STAINS AND PREPS

GRAM STAIN 14AUG97 0722
FEW GRAM POSITIVE RODS

PENDING RESULTS

14AUG97 0024 C URINE STAIN

MedWatch #13202
2/4,5/99 JAH
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END OF REPORT

PRINTED: 15AUG97 0501 [redacted]

[redacted]

Patient: [redacted]
Age: 20 YRS SEX:F
Med Rec Number: [redacted]
Financial Number [redacted]
Admit Date: 13AUG97

Location: [redacted]
Physician(s): [redacted]

EMERGENCY DEPARTMENT LABORATORY REPORT

ENDOCRINOLOGY

Procedure: S.PREG
14AUG97 0035 NEGATIVE

HEMATOLOGY

COMPLETE BLOOD COUNT

Procedure:	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW
Reference:	5.0 - 10.0	4.00 - 5.20	12.0 - 16.0	36.0 - 46.0	080 - 099	25.0 - 35.0	31.0 - 36.0	11.5 - 14.5
Units:	K/CUMM	M/CUMM	G/DL	%	FL	PG	G/DL	%
14AUG97 0035	9.8	4.56	13.6	40.2	088	29.7	33.7	13.8

AUTOMATED DIFFERENTIAL

Procedure:	NEUTRO	LYMPH	MONO	EOS	BASO
Reference:	40 - 75	16 - 46	0 - 9	0 - 4	0 - 2
Units:	%	%	%	%	%
14AUG97 0035	56	37	4	1	2

Procedure:	NEUTRO ABS	LYMPH ABS	MONO ABS	EOS ABS	BASO ABS
Reference:	1.8 - 7.8	1.0 - 3.4	.0 - .8	.0 - .4	.0 - .2
Units:	K/CUMM	K/CUMM	K/CUMM	K/CUMM	K/CUMM
14AUG97 0035	5.6	3.6 H	.3	.1	.2

Procedure:	PLATELET CT
Reference:	150 - 350
Units:	K/CUMM
14AUG97 0035	162

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Symbols and Notes:
H = High

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OUTPATIENT